

## GUEST EDITORIAL

# William Stewart Halsted Is Alive and Well . . .

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William Halsted was buried in a small cemetery in Brooklyn, New York. His concepts of the treatment of breast cancer were buried some years later with the rise of conservation therapy for breast cancer and the theory that inherent properties of the cancer or failure of host defenses were responsible for the deaths of patients from this disease. At that point in time systemic treatment was touted as the only chance for cure and some physicians suggested that the type of local treatment was unimportant.

In two previous editorials in 1994 and 1996, in this Journal, I pleaded for a return to rational treatment of this disease based on adequate local and lymph node resection [1,2]. Many surgeons have abandoned complete lymphadenectomy and, in fact, some question any need for lymph node dissection in breast cancer! We tried to address this problem with a study presented at the American Surgical Association and published [3] in which we concluded in part: "Local breast cancer spreads to lymph nodes as micro metastases, then macro metastases; it then spreads to other lymph nodes and metastasizes."—a distinctly unpopular view!!

In a collective review of post excisional recurrence of carcinoma of the breast [4], we indicated the poor prognosis in patients with recurrent breast cancer as demonstrated in several randomized studies. Now with the publication of two randomized studies of radiation in breast cancer patients [5,6] the paradigm is thrown into reverse and new (old) concepts have reemerged. Both articles reported in the *New England Journal of Medicine* review the efficacy of radiation therapy added to standard treatment for advanced operable breast cancer in prospectively randomized patients followed for 15 y. In the past we have had studies which failed to demonstrate a survival advantage for radiation therapy, but these trials included all stages of patients. The importance of these recent studies were that one included only stage II and III premenopausal patients while the other included only positive node premenopausal patients (very high risk groups).

The results of those recent studies were remarkably similar with a disease free survival advantage in the irradiated group of 17% in one study ( $p = .007$ ) and 14% in the second ( $p = .001$ ). How is this possible if the advanced disease is disseminated? Unless there is a hypothesis that radiotherapy improves the host defenses (contrary to what is commonly believed), the only logical conclusion is that improved local control leads to improved survival. Clearly, the appropriate treatment principles for breast cancer are: wide local excision with clear margins (mastectomy when appropriate), complete axillary node resection and post operative radiation in advanced cases with chemotherapy when indicated. The general principles of cancer surgery should not be abandoned. In this regard, breast cancer is no different from most other solid cancers.

## REFERENCES

1. Gardner B: It's time to stop the pendulum. *J Surg Oncol* 1994;57:1-2.
2. Gardner B: Breast cancer: A different cancer? *J Surg Oncol* 1996;63:139-140.
3. Gardner B, Feldman J: Are positive axillary nodes in breast cancer markers for incurable disease? *Ann Surg* 1993;218:270-278.
4. Zavotsky J, Gardner B: Postexcisional recurrence of carcinoma of the breast. *J Am Coll Surg* 1996;182:71-77.
5. Overgaard M, Hansen PS, Overgaard J, et al.: Postoperative radiotherapy in high-risk premenopausal women with breast cancer who receive adjuvant chemotherapy. Danish Breast Cancer Cooperative Group 82b Trial. *N Eng J Med* 1997;337:949-955.
6. Ragaz J, Jackson SM, Le N, et al.: Adjuvant radiotherapy and chemotherapy in node-positive premenopausal women with breast cancer. *N Eng J Med* 1997;337:956-962.

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